ARTHROTOMY FOR IRREDUCIBLE SUBCORACOID DISLOCATION.

DR. LUCIUS W. HOTCHKISS presented a man, thirty-eight years old, an iron-worker, who was admitted to the hospital last July for an irreducible dislocation of the right shoulder-joint of ten weeks' standing. The dislocation was of the subcoracoid variety, and it could not be reduced by any of the usual methods.

July 28, 1903, an arthrotomy was done to effect reduction. The usual incision was made between the pectoralis major and deltoid, and the head of the bone exposed. It was extremely difficult to make out the exact anatomical relations of the parts, and before reduction could be accomplished it was found necessary to divide, in succession, the long and short heads of the biceps and all the muscles attached to the greater tuberosity. It was impossible to make out what particular muscle had prevented reduction before their division, though the subscapularis was last divided, and after this reduction was effected. The wound healed by primary union, and the arm was treated first by passive and subsequently by active motion. Since the operation, the function of the limb had gradually improved, and the man had returned to his work and was again able to use a heavy sledge-hammer. The head of the bone was now in its proper position, but ankylosed, and the range of motion constantly increasing.

Dr. Hotchkiss said that in another case of irreducible subcoracoid dislocation in which he had also performed arthrotomy last summer, the operation was done for persistent neuralgia caused by pressure of the head of the bone on the brachial nerves. The pain was entirely relieved by the operation, and the functions of the shoulder-joint, which in this case were very good before the operation, were not impaired.

DR. JOHN F. ERDMANN said that about a year ago he saw a case of subcoracoid dislocation in which the capsule of the joint had a button-hole tear which grasped the neck of the humerus, preventing its reduction by the usual methods; that in addition there was a complete evulsion of the greater and lesser tuberosities, and that the long head of the biceps was displaced outward and wound spirally around and posterior to the head of the humerus. Operation was done; a torn portion of the tuberosities was removed, capsule was split transversely, and the tendon of

the biceps reduced; this procedure being followed by easy reduction; the tear cut in the capsule was sewn as much as possible, although a gap was left in the tear about one-quarter inch wide. This was bridged over by a continuous suture of kangaroo tendon.

Patient when shown had practically all the functions with which the shoulder-joint is endowed, except that of retaining the arm in condition of hyperextension from the body.

DR. WILLY MEYER said that Dollinger considered the subscapular muscle to be the chief offender in the prevention of reduction in this form of shoulder dislocation. As soon as its tendon had been divided, and no other besides, reduction generally was feasible.

DR. HOTCHKISS said that, although the head of the humerus was underneath the coracoid process, there was a distinct membrane covering the head of the bone. Probably the lower end of the capsular ligament had been torn, and a portion of it had been carried forward with the head. The long head of the biceps was cut because it was very taut, and apparently was partly responsible for the interference with reduction.

POSTOPERATIVE INTESTINAL OBSTRUCTION.

DR. GEORGE E. BREWER presented a girl, thirteen years of age, who was admitted to the Surgical Division of the Roosevelt Hospital, in October last, suffering from abdominal pain, vomiting, and general weakness. One year before admission she had undergone an operation for acute appendicitis with abscess, from which she slowly recovered.

The present illness began five days before admission, with colicky pains in the abdomen and slight distention. Various cathartic remedies were employed, but without result. The lower bowel was emptied by an enema. The vomiting was at first moderate, but became more violent and persistent during the second and third days. On the fourth and fifth days there was an apparent subsidence in the acuteness of the symptoms, but no movement from the bowels or passage of flatus, although high enemata were constantly employed. On the sixth day of her symptoms she was seen by the writer, who found her in an extremely critical condition; the temperature was 101° F., the pulse 120, weak and compressible; the face drawn, the eyes sunken, the extremities

cold, and the entire body bathed in cold perspiration. There was considerable distention of the abdomen, with tenderness and slight rigidity over the lower right rectus muscle.

She was immediately prepared for operation, and under ether anæsthesia an incision, eight inches in length, was made through the right rectus muscle, and the transverse colon sought for and found to be collapsed. The cæcum was next examined, and also found to be empty. The ileum, at its junction with the cæcum, was found and traced downward to the pelvic cavity. About seven inches from its colic extremity it was found to be acutely constricted by a loop passing under a firm fibrous band, the result of her former appendicitis. Beyond this loop the small bowel was greatly distended. As soon as the constriction was relieved, fluid and gas were seen and heard to pass rapidly to the colon. The point of constriction was dark in color and ulcerated. It was protected by suturing a layer of the omentum over its injured segment, anchored near the cutaneous margin, and a large Mikulicz tampon introduced, as it was feared a fistula would result. The tampon was allowed to remain in place two weeks, after which the wound slowly healed. The recovery was uneventful.

GASTRO-ENTEROSTOMY.

Dr. John Rogers, Jr., read a paper with the above title, for which see page 512.

Dr. Willy Meyer said his experience with gastro-enterostomy by the elastic ligature method was limited to four cases. Of these, three had recovered and one died, probably of acetonæmia or of sepsis. If the technique of the method was properly carried out, he did not see how the ligature could fail to cut through. He preferred the No. 3 ligature, which was certainly strong enough for the purpose. A very favorable feature of the method was that it effected an anastomosis of good size, at least one or two inches. Another point in its favor was that it could be done very rapidly. The speaker said he was formerly a strong advocate of the use of the Murphy button in these cases, but one serious objection to its use was that it was apt to fall back into the stomach and eventually do harm. The latter was not always the case, however, as he knew of one instance where the button was located in the stomach by means of the X-rays five years after operation, and its presence there had apparently not given rise to any injurious symptoms.

DR. ERDMANN said that in one case where he did the McGraw operation the patient, a man sixty-two years old, died on the seventh day from asthenia. The patient was fed by the mouth on the third day; this apparently set up vomiting, and rectal feeding was again resorted to. At the autopsy, a section of the stomach and intestine was removed, and the stomach wall showed a distinct slough, about the size of a silver quarter, which apparently would have come out in the course of another twenty-four hours. The slough consisted of that portion of the stomach wall that was tied off by the ligature, and the question arose in his mind whether by this method (the McGraw) the tissues were cut through or caused to slough out. There was no peritoneal invasion.

Dr. Erdmann said that this class of patients was usually asthenic, and the early introduction of food into the stomach was a very important factor. On that account he favored the use of the Murphy button, which was usually surrounded by a sufficient plastic exudate in the course of eight or ten hours after the operation to permit the introduction of peptonized milk into the stomach. In one case where he used the button the patient was able to sit up in bed in twelve hours and take broth and peptonized milk.

DR. JOHN B. WALKER said that his experience had led him to favor the posterior operation, suturing if possible; if this could not be done, he used the Murphy button, and did an entero-enterostomy to avoid the formation of a vicious circle.

DR. F. KAMMERER said he had found the posterior operation with the button entirely satisfactory, and he had never had a vicious circle occur. He did not think it necessary to do an additional entero-anastomosis when the posterior operation was done. In former years, when he used Abbe's rings and Senn's plates and the simple suture, and operated by the anterior method, the formation of a vicious circle was not infrequently observed. The speaker said he thought the application of the McGraw ligature and the running suture would take fully as much time as the introduction of the Murphy button without the reinforcing sutures; the latter he did not think were essential, and he never used them.

DR. WILLY MEYER said the possibility of the Murphy button dropping back into the stomach was an objectionable feature to its use in gastro-enterostomy. If this accident could be success-

fully eliminated, it would represent the best artificial means of doing this operation. So far, we had no means at our disposal to surely prevent its occurrence. By the application of the ligature or sutures the use of this foreign body could be avoided. It should not be employed in those cases where there was any suspicion of an ulcer of the stomach.

Dr. Howard Lilienthal said he thought the subject could be divided advantageously into two parts,—one relating to malignant and the other to non-malignant cases. In the latter class of cases he had done the Finney operation four times, and it apparently left nothing to be desired. It was simple, rapid, and clean, and in all four of his cases the patients made a rapid recovery. His last case was one in which the Finney operation was secondary to an operation for pyloric stenosis, in which he had found a band constricting the duodenum. This was divided and the cause of the obstruction was thought to be relieved, but no relief in the symptoms followed the operation. Four days later the wound was reopened and a Finney operation was done. The pylorus itself proved to be the real cause of the obstructive symptoms. The speaker said that Finney himself did this operation also in cases where there were good-sized masses and adhesions about the pylorus, and where, under ordinary circumstances, another operation would be considered preferable. In the malignant cases in which gastro-enterostomy without any resection was indicated, Dr. Lilienthal said he was very much in favor of the button. He knew of cases where the button dropped back into the stomach, and had even devised a special button to prevent the occurrence of that accident. One-half of this button was big, the other half small; he had never had this modified button drop back into the stomach, nor had he seen this accident occur with the Weir button. The posterior operation was the one he always favored. The speaker recalled one case where two Murphy buttons were used in the abdomen, and both failed to pass. They were subsequently located by the X-ray in the right iliac fossa. The patient complained of cramps, and was advised to have the buttons removed by another operation, but he was lost sight of.

Dr. Lilienthal said he was induced to try the McGraw method of gastro-enterostomy in a single instance. In tying the ligature, he tied it as firmly as he could; but the patient's symptoms were apparently unrelieved by the operation, which was an anterior

one. After ten days had elapsed he again opened the wound, and with the exploring finger he could feel the McGraw ligature in its original position. It had apparently not cut through. Another ligature was thereupon placed about an inch distant from the original one, but the patient continued to vomit; and, although two weeks had elapsed, her symptoms were unrelieved. While he was contemplating a third operation the patient suddenly began to improve, and, although the ligature was never found in the stools, he had every reason to believe that the operation proved successful. The patient's vomiting ceased and her general condition improved; but Dr. Lilienthal said that his experience with the McGraw method in this case had proven so unsatisfactory, that he would not resort to it again if he could help it.

DR. ROGERS, in reply to a question, said that a few writers mentioned the possibility of a recurrence of the symptoms after operation for benign stricture of the pylorus, from cicatricial contraction of the operative fistula, and emphasized the importance of narrowing the pyloric outlet. The speaker also said he recently heard of a case of gastro-enterostomy in which the Weir button had dropped back into the stomach, and had to be subsequently removed by operation. The McGraw elastic ligature method, which Dr. Meyer favored, had very few advocates. He did not think it possessed any advantage over the button as a time-saving method, and the reports of failures by this and all two-stage methods were so frequent that at least they could not be considered the methods of choice.

Stated Meeting, December 23, 1903.

The President, HOWARD LILIENTHAL, M.D., in the Chair.

ACUTE TRAUMATIC STRANGULATED HERNIA.

DR. IRVING S. HAYNES presented a man, aged thirty-eight years, who, in going down an areaway steps, stumbled and fell, striking his left groin against a projecting corner of the stone coping. He was at once seized with an agonizing pain, and his

condition was such that an ambulance was summoned and he was taken to the hospital, where he arrived in a state of almost collapse. Upon examination, a swelling was found over the external ring, and a diagnosis of acute strangulated hernia, of traumatic origin, was made. The House Surgeon was instructed to operate immediately, and upon slitting up the external oblique he found that the hernia had broken through the fibres of the internal oblique and transversalis just above the conjoined tendon. The peritoneum was not ruptured. The hernial sac was opened, and a coil of very dark, œdematous gut was found and reduced.

A further examination revealed a second swelling at the internal ring, and upon slitting up the fascia this proved to be an ordinary congenital hernial sac, for which the usual Bassini operation was done. It was subsequently learned that three years before the man had noticed a small, tender lump in the left groin. He consulted a surgeon regarding it, who told him that he had a hernia, and advised a truss. The hernia did not cause the patient any inconvenience, but soon disappeared, and he did not follow the surgeon's advice.

In reply to a question, Dr. Haynes said there were no symptoms pointing to injury of the cord or testis. The patient made an uneventful recovery and left the hospital on the twelfth day after the operation.

Dr. Bern B. Gallaudet said he thought a sharp distinction should be drawn between the hernia and the sac in so-called traumatic herniæ. In the true traumatic type, of which there are a few on record, there is no hernial sac, the hernia having simply broken through the peritoneum and is found in the tissues of the scrotum without any sac. In the common variety, on the other hand, the sac is present from birth, and the hernia is the result of the trauma.

Dr. Haynes said that the direct hernia, to which he had applied the term traumatic, was through the ruptured muscle. The peritoneum was not ruptured. The second hernia found was of the ordinary congenital type.

TRAUMATIC PYELOPARANEPHRIC CYST.

Dr. Bern B. Gallaudet read a paper with the above title, for which see page 573.

Dr. Brewer said that injuries affecting the kidney region

were always interesting, especially in some of their later manifestations. A very slight injury was sometimes sufficient to produce a rupture of the kidney. The speaker said that the case reported by Dr. Gallaudet reminded him of a rather rare condition to which Morris had called attention, in which rupture of one of the branches of the renal artery was followed by the formation of a hæmatoma, sometimes of enormous size, with a tenacious capsule. The condition Morris described, however, was of very rapid formation, and sometimes disappeared spontaneously.

CYSTIC KIDNEY.

DR. PARKER SYMS presented a specimen removed from an extremely neurotic woman, thirty-nine years of age, who had been referred to him with a diagnosis of floating kidney. When Dr. Syms saw the patient in consultation, he found a floating kidney, but it could be readily made out that the organ was not of normal size. It was much enlarged and distinctly lobulated, and very freely movable. The woman was practically an invalid, suffering from the pressure of the kidney on the pelvic organs.

The operation was performed at Stamford, Connecticut, on December 14, Drs. Pierson, Tiffany, and Sherrill assisting.

The incision was made parallel to the twelfth rib, and had to be extended far forward owing to the size of the kidney. When the peritoneum was reached, it was not opened, but was pushed from the wall. An enormously enlarged cystic kidney was found. Apparently there was but little renal tissue left, so the organ was removed, though with some doubt as to the ultimate outcome, on account of the well-known fact that in these cases of cystic kidney both organs are apt to be involved.

Before operation careful examination had been made of the other side, and, though the woman was an extremely thin one, with flaccid abdominal walls, the right kidney could not be palpated, and therefore it was inferred that it was not cystic, or if cystic it was in far better condition than the organ removed.

Before removing the kidney, Dr. Syms and the others debated as to the advisability of opening the peritoneum and passing the hand across the interior of the abdomen to palpate the right kidney, but the woman was so feeble before operation that it was decided best not to subject her to any unnecessary manipulation.

The enormous kidney was delivered and removed; the vessels and ureter being tied separately, the latter being cauterized. The kidney measured seventeen inches in circumference and was made up of a number of cysts. There was apparently a very small area of renal tissue in the region of the pelvis.

The operation was performed December 14. On December 29, a letter from Dr. Pierson reports the patient as having made satisfactory progress, showing that her remaining kidney is performing sufficient function and indicating that the operation was a wise one.

DR. HAYNES said that some years ago he saw a woman, forty-five years old, who was brought to the hospital complaining of a severe pain in the lumbar region. A firm tumor could be felt over the region of the left kidney, which upon operation proved to be one of these cystic kidneys. It was enormously enlarged, and he decided to remove it. The kidney measured nine by four by three and one-half inches. About a fortnight later the woman died of uræmia, and at the autopsy the opposite kidney was also found to be in a cystic condition. The speaker said he thought the consensus of opinion was that these cystic kidneys had better be left alone. In the case he had in mind the remaining kidney was much enlarged, but it could not be palpated at the time of the original operation.

DR. LILIENTHAL said that in view of Dr. Haynes's experience, he would not feel inclined to remove one of these cystic kidneys unless he could feel assured that the opposite kidney was at least fairly normal. Before removing a kidney for any cause, he thought it was a good plan to ascertain the condition of the opposite kidney by incision and palpation. This second incision entailed very slight additional shock, and the speaker said he did not consider it any more dangerous than it was to catheterize the ureter of the opposite kidney in suppurative cases. The latter procedure he disapproved of.